Free Clinics in the United States: An Exploratory Review

An Honors Thesis (HONRS 499)

by

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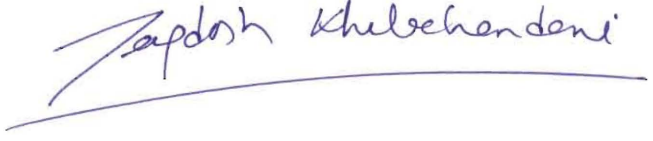

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Abstract

Free clinics are spread across the nation and serve millions of the poor and uninsured in our communities. As these clinics strive to provide quality care for their patients who have fallen through the cracks of the healthcare system they face many issues. The purpose of this paper was to use previous research and literature to develop a better understanding of free clinics as a collective whole with hopes of learning more about the issues they face in the process. By showing how clinics are organized and funded, what types of patients they see for what reason, and how they are staffed with medical professionals, it can be seen how they work and what purpose they serve.

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I would like to thank Dr. Jagdish Khubchandani for being my advisor for this project. I am lucky to have had an advisor who is so experienced in research and passionate about community health. Without his guidance, this paper would not have been possible.

I would also like to think the staff and volunteers at Compassionate Care of Shelby County for all they do for the uninsured of my hometown. Their hard work and passion for serving the underserved improve the lives of their patients but also ignited my interest in free clinics.

Contents

Chapter 1: Introduction

Background

Adequate healthcare is necessary in order to live a long a full life, but for those who cannot afford medical insurance, it is often out of reach. In recent years, medical insurance coverage has become a major issue as the percentage of employers offering healthcare benefits decreased from 69% to 60% between the years of 2000 and 2007(Price et al., 2010). In 2010, there were approximately 50 million uninsured individuals living in the United States (U.S. Census Bureau, 2010). This group is made up of a diverse population ranging from the homeless to the working poor who qualify for insurance but are unable to pay. In many communities free clinics have stepped up to fulfill the medical needs of these individuals. These clinics act as a safety net and without their presence the people in need would have few options (Douangmala, Hayden, Young, Rho & Schnepper, 2012; Nadkarni & Philbrick, 2003; Notaro et al., 2011; Parizot, Chauvin & Paugam, 2005;). According to a survey from 2010, a majority of free clinic patients said that without their clinic they would find another free clinic, go to the emergency room, or simply not seek out medical attention. Without any free clinics, it seems likely that people would either live in poor health, unable to seek help when ill, or find themselves in debt due to hospital bills that they simply cannot pay (Gertz, Frank & Blixen, 2010).

The current healthcare system has many niches, but one of the lesser known, and sometimes unsupported areas may be 'community based free clinics'. These clinics prevail across the country with little to no academic research or government support and still manage to make an impact in community health by providing

millions of patients visits each year (Notaro et al., 2011; Darnell, 2010). Due to the fact that free clinics are independent of any government organizations they tend to vary greatly based on several factors such as funding and organization, but there are some common traits often seen in free clinics across the country. Most free clinics tend to be community centered, run by volunteers who receive little or no compensation, offer services to patients at little to no cost, strive for quality care for patients regardless of situation, and are geared toward parts of the population that are lacking in medical care and support (Department of Health Policy, 2012; Fertig, Corso & Balasubramaniam, 2012; Nadkarni & Philbrick, 2003; Weiss, 2006). Despite these similarities, the differences between individual clinics are seen in the details. They offer different types of healthcare services, find funding from diffeFrent sources, have various working days and hours, and operate with a varied number and type of staff and/or volunteers. One popular quote that is frequently referenced in free clinic literature comes from Brooke Powers, a Program Manager from ClinicNET, she said, *"If you've seen one clinic, you've seen one clinic."* This statement describes a common theme seen in the many articles that indicate that there is a huge variation from clinic to clinic (Weiss, 2006; www.echoclinics.org, 2012). However, there is one issue that many studies noted clinics to have in common: they are extremely busy (Darrow, 2007; Nadkarni & Philbrick, 2003; Tennant & Day, 1974).

Purpose of the Review

The purpose of this review is to summarize information gathered from studies across the years to assess: How free clinics are organized, how they function,

and what are the funding sources for these clinics? Who are their patients and what sort of medical care are they receiving? What is the quality of that care? Answering these questions is an important part of being able to understand free clinics and the services they provide to American communities. Additionally, I am discussing issues like the future, recommendations for research, and practice.

Chapter 2: Methods

Methods

The researcher contacted the Ball State University reference librarians to find reliable and appropriate databases to search for peer reviewed scientific literature on free clinics. The researcher chose to use CINAHL [Cumulative Index to Nursing and Allied Health Literature], ERIC (EBSCOHost), Health Source: Nursing/Academic Edition, Medline (EBSCOHost), ProQuest Nursing and Allied Health Source, ProQuest Dissertations and These A& I, and Web of Science. The databases chosen are health related or educational based databases at Ball State University Libraries.

Limitations of the Study

1.) Limited to articles written in English.

2.) Using only studies of free clinics located in the United Sates.

3.) Observational studies used which are not always objective.

4.) Limited to only the journals available through Ball State University Libraries Databases.

5.) Limited by missing articles.

6.) Year of articles review.

Chapter 3: Results

Origins and History

Free clinics first appeared in the 1960s when a new culture of young people spread across America along with their drug- related problems, STDs, and unplanned pregnancies (Department of Health Policy, 2012; Tennant & Day, 1974). The first free clinic was cited to be The Haight-Ashbury Free Clinic, which was founded in 1967 in San Francisco, California. This clinic, like many of the early free clinics, was dealing with youth, minorities, and the hippie movement. The largest majority of patients were hippies coming in with drug related issues (Gordon 1976; Weiss, 2006). With little funding and a struggle to find medical professionals willing to volunteer, staying open was difficult for a clinic in the 60s and 70s. At the end of the 70s the focus of free clinics moved from hippy drug users to the uninsured and working poor (Weiss, 2006). By the end of the late 70s, free clinics in America were estimated to have between two and three million patient visits a year (Gordon, 1976). In the early 1990s President Bush pushed for free clinics, stressing the need for nongovernmental organizations to fill the gaps left by Medicaid and mainstream medicine for uninsured citizens (Weiss, 2006). Little was accomplished in way of policy changes encouraging the opening of more clinics, but the late 1990s experienced a sharp rise in the number of free clinics in America. Free clinics continued to gain popularity through the 90s and today act as a significant safety net in the American healthcare system (Nadkarni & Philbrick, 2003).

Numbers and Prevalence

Free clinics can be found serving patients across the nation, but Alaska is the only state to have no identified free clinics. The National Association of Free Clinics (NAFC) states that there are over 1,200 free clinics at this point in 2012(NAFC, 2012). However, because there is no organization that directly monitors all free clinics, it is difficult to determine an exact number or have a clear understanding of how clinics are distributed around the nation (Keis, DeGeus, Cashman & Savageau, 2004). According to a 2010 study, 81.8% of existing clinics had formed since 1990 and 37.7% had formed since the year 2000 (Darnell, 2010). With nearly 50 million uninsured citizens free clinics are not numerous enough to be available to all uninsured people (Kaiser, 2012; Weiss, 2006; Tennant & Day, 1974). However, studies suggest that free clinics are useful in filling in the gaps left by demands for care that are not being met by any government program (Darnell, 2011; Epstein, 2001; Geller, Taylor & Scott, 2004).

Why clinics prevail in some communities and not others is also of interest, and Darnell's study from 2011 had some unexpected results. This study found that free clinics do not seem to exist in areas where the needs are the greatest as one would assume. The study suggested that the existence of free clinics was more based on the availability of financial and human resources to start and sustain the clinic. Areas with people and organizations willing to donate money and supplies and medical professionals who will volunteer are more likely to start a free clinic, regardless of the level of need in their community. It seems that founders of free clinics have a large affect because they see need in their community, and perceived

need may be more important that actual need to spark the formation of a new free clinic in any given community (Darnell, 2011).

Funding and Organization

The funding of free clinics varies widely, but there are some similarities that are shown in many studies. In a survey of 764 free clinics across the country, there were 10 different major sources that clinics reported receiving funding from. A majority of the clinics reported receiving funding from individual donors, foundations, corporations, civic groups, and churches. These clinics are all tax exempt and at least 30% reported receiving funding from hospitals, patients, United Way, and the government at either the federal, state, or local level. A small percentage reported receiving funds from a university or medical school, or from third party payers such as insurance companies. 58.7% of 764 free clinics received absolutely no revenue from the government. The budgets of these clinics fell within a wide range but, according to one study the average annual operating budget was $287,810 (Darnell, 2010).

The organization of free clinic is also varied. Clinics range from completely independent, to being affiliated with a hospital, university or medical school, church, or homeless shelter. Weekly number of hours open range from 5 to 41 hours. According to a 2010 survey, most are independent entities operating as a medical clinic in a building that is rented, owned, or borrowed for an average of 18 hours a week (Darnell, 2010).

Free clinics most often have very few paid employees and many have none at all. A survey of 106 free clinics showed that 41% had no full time staff, and were

operating with an average of 2 part time employees. For the clinics who had full time employees, the average number was 2. Of the paid staff, about two thirds of free clinics have a paid executive director and about half have a paid administrative staff-person (Geller, Taylor & Scott, 2012). Clinics also rely heavily on a volunteer board of directors to make decisions pertaining to the organization and promote awareness of the clinic to the community (Darrow, 2007; Tennant & Day, 1974). With the combination of so few paid staff and the relatively small budget, free clinics are very reliant on volunteerism in their community. Clinics have volunteer physicians, nurses, nurse practitioners, pharmacists, dentists, secretaries, social workers, and mental health professionals (Darrow, 2007; Fertig, Corso & Balasubramaniam, 2012; Geller, Taylor & Scott, 2004; Nadkarni & Philbrick, 2005).

More recently, free clinics have formed associations of free clinics at the state, regional, and national levels ("State/regional associations," 2012). This type of organization has become useful in the recent years because they advocate for clinics at the corporate and governmental levels in attempts to influence pertinent policies, find major sources of funding, and ensure that clinics are aware of the resources that are available to them. However, at this point in time, individual clinic involvements in these associations are not mandatory (Department of Health Policy, 2012; Issacs & Jellinek, 2007).

Role in Health Care System

Role in Medical Care

Across the literature regarding free clinics, studies refer to the clinics as a safety net offering medical care to the uninsured while protecting emergency

departments from unnecessary and costly visits (Darnell,2011; Department of Health Policy, 2012; Epstein, 2001; Geller, Taylor & Scott,2004) . In 2008 the estimated cost of uncompensated health services provided to uninsured individuals was $56 billion (Fertig, Corso & Balasubramaniam, 2012). This seems reasonable keeping in view the number of uninsured individuals has been increasing for a number of years. Between 2000 and 2005, more than 17 million people either lost their insurance or signed up for Medicaid (Issacs & Jellinek, 2007). In 2007, another decline began and the number of uninsured individuals increased every year until 2011 when almost 48 million people were without insurance (Kaiser, 2012). Despite the fact the literature suggests that free clinics are an important part of the health care system safety net, several investigations conclude that the clinics act as more of a band-aid than an actual solution (i.e. patchy access to often times substandard care for individuals at a socio-economic disadvantage). One article suggests that most free clinics are not equipped to provide consistent, comprehensive care to its patients on a long-term basis. Due to these issues researchers have concluded that even though free clinics have become an important part of the safety net, they are only making up for a broken healthcare system and should be treated as a last resort (Department of Health Policy, 2012; www.echoclinics.org, 2012; Hall, 2011; Keis, DeGeus, Cashman & Savageau, 2004).

A study by Epstein (2001) reports the rates of preventable hospitalizations, which was defined as hospitalizations that would have been unnecessary had the condition been treated prior on an outpatient basis. The study reported that while the rates increase in correlation to the elderly, education level, race, age, and gender,

the most direct correlation is between preventable hospitalizations and poverty rates. Areas with more impoverished citizens have higher rates of preventable hospitalizations and this anomaly taxes the health care system of those areas. Also, the uninsured and those insured by Medicaid were found to have significantly higher rates of these preventable hospitalizations than the rest of the population studied. The study also explored areas that are within the service area of a free clinic and found that preventable hospitalizations were reduced, on average, by 2.3 per 1,000 people in that area. The study concluded that the presence of free clinics improve access to primary care to people who are vulnerable to preventable hospitalizations (Epstein, 2001). It could thus be postulated that free clinics can help lower the cost associated with these hospitalizations, and this is an additional way that free clinics act as a safety net in the current health care system (Epstein, 2001).

Several studies have been conducted to gather more information about the patients who seek care at free clinics. In a national assessment of free clinics, 281 clinics reported that their patients fit into one or more of eleven different categories: uninsured, low income, working poor, under-insured, homeless, indigent, medically underserved, unemployed, migrant workers, and recent immigrants (Nadkarni & Philbrick, 2005). Another investigation found that patients were disproportionately more likely to be females, with average ages between 20 and 44 years. Also, this study also found that patients were more likely to be regular smokers in comparison to the general population. A vast majority (90%) of patients surveyed in this study were between the ages of 18-64 years and the study suggested that this was the group of people who were most in need because they do

not qualify for any of the government programs for children or the elderly (Notaro, Khan, Bryan, Kim, Osunero, Senseng, Eithen & Desai, 2011). A study from Massachusetts informs that half of the patients over the age of 18 years that were surveyed reported being unemployed, and a quarter surveyed reported a language barrier that made them unable to converse with health care providers. This study also reported that a vast majority of free clinic patients are in the low-income group. An overwhelming majority (90%) of patients had an annual household income of less than $30,000 and for 58% this income is even lower, at less than $15,000 a year. (Keis, DeGeus, Cashman & Savageau, 2004).

One study found that a majority of clinics have at least a small, and in some cases large number of homeless patients. They found that these individuals come to clinics with a higher rate of hepatitis, tuberculosis, STDs, and mental illnesses when compared to the clinic patients who are not homeless (Notaro, Khan, Kim, Nasaruddin & Desai, 2012). While we discuss the living arrangements of patients of free clinics, it would be prudent to look at the migration status and national orgin of individuals who receive care at free clinics. In general, free clinics are not majorly concerned about the patients' migration status and national origin. One study reported that a disproportionally large number of immigrant patients and the clinics surveyed reported that they had a "don't ask" policy in regards to dealing with migration status and documentation (Keis, DeGeus, Cashman & Savageau, 2004).

With a majority of free clinic patients being uninsured, many have no other access to primary healthcare (Gertz, Frank & Blixen, 2010; Epstein, 2001). In a clinic based study, a third (34%) of the surveyed patients said that they were unaware of

any place to receive healthcare besides their free clinic (Keis, DeGeus, Cashman & Savageau, 2004). According to Keis's assessment the uninsured free clinic patients reported that they did not know where they would go for urgent medical care and were more likely to delay seeking care due to lack of funds when compared to the general population. Free clinic patients are also more likely to report their health status as "fair" or "poor" which the investigators hypothesized could likely be attributed to their lack of primary care. This particular study had additional relevant findings. First, a majority of patients surveyed in this study were first time patients and only 18% had been visiting the clinic for a year or longer. The authors concluded that long term patients continued to use clinics due to a need for free prescription drugs. Second, while half of the patients reported having a health problem that required them to take medication regularly, 66% of these patients indicated that they were not able to take the medication as prescribed, most often due to cost (Keis, DeGeus, Cashman & Savageau, 2004).

The aforementioned findings mirror the findings of several other studies wherein it was reported that patients who seek care from free clinics have several health risk behaviors and are at a socio-economic disadvantage (Epstein, 2001; Geller, Taylor, & Scott, 2004; Keis, DeGeus, Cashman & Savageau, 2004).

In the literature of a more broad view of health care, free clinics are often not even considered. They have been left out of studies concerning the healthcare safety net where Federal Health Care Center Programs (FHCCP) was the focus. The major difference between free clinics and FHCCP is government funding and regulation. This shows a deficiency in the literature because while FHCCP served an estimated 6

million uninsured patients in 2006, free clinics were estimated to have served almost 2 million uninsured patients that same year (Darnell , 2010). In 2009, clinics were found to serve 38% of the uninsured citizens of America (Notaro et al., 2011). Because free clinics are often overlooked in studies, research, and literature, they are also under-represented in policy debates (Darnell, 2011).

Role in Disease Prevention and Health Promotion

Free clinics offer a very wide range of services from chronic illness care and regular checkups to reproductive health services and psychiatric care. Some of the most common chronic illnesses treated in free clinics are hypertension, diabetes, lipid abnormalities, asthma, and heart disease (Douangmala, Hayden, Young, Rho & Schnepper, 2012; Gertz, Frank & Blixen, 2010; Keis, DeGeus, Cashman & Savageau, 2004; Notaro et al., 2011;). Depression and anxiety are also very common diagnoses in these clinics (Nadkarni & Philbrick, 2005). Medications to treat these health issues are also a major service provided by free clinics. A national survey of free clinics found that a majority (84%) of clinics surveyed are dispensing medications, only 30% of clinics had a licensed pharmacy on site, the rest of the medications were given out under the authority of a physician. As another method of providing medications to their patients, majority (89%) of clinics help enroll patients in prescription assistance programs either through the drug manufactures or generic drug savings programs. Clinics also rely on donations of medications and samples to fill the needs of their patients (Wiesner, Steinke, Vincent, Record & Smith, 2009).

Quality of Care

Free clinics strive to provide quality care at no cost to their patients, and according to much of the literature, are quite successful. According to patients surveyed at 41 clinics across the nation, the vast majority (97%) surveyed were satisfied with the care they received. When asked further, more than 3 in 4, (77.3%) of the patients responded that they received better care at the free clinic than they had received from their previous health care provider (Gertz, Frank & Blixen, 2010). This is a significant improvement from the early years of free clinics. A study from early 1970s indicated that all clinics surveyed showed evidence of significant deficiencies in quality of care that had a negative affect on patients. (Tennant & Day, 1974) One can assume that the quality of care in free clinics has been improving over the last forty years.

One common and significant issue affecting quality of care in free clinics is brought upon by the way clinics are staffed with healthcare providers. Most commonly, healthcare providers are volunteers who see clinic patients one or two times a month, which means that patients are not likely to see the same provider if they have multiple visits. This can affect overall quality of care by lack of consistent treatment from a single healthcare professional (Nadkarni & Philbrick, 2005). Also, with a majority of medications that are dispensed without the involvement of a pharmacist, the benefits that have been seen in patient outcomes with a pharmacist in the mainstream healthcare system is lost on these patients (Wiesner, Steinke, Vincent, Record & Smith, 2009). However, studies have shown that a majority of free clinic patients would simply not seek care if free clinics did not exist. In one

study the authors concluded that free clinics act to provide a source for healthcare and as individuals utilize this resource and receive healthcare, their quality of life can be improved. For this reason, the argument can be made that care from free clinics, even if the quality is not that of full price primary care, is better than no care at all (Douangmala, Hayden, Young, Rho & Schnepper, 2012).

Challenges

Even though the free clinics aspire to provide subsidized or free care to individuals who probably need care the most, free clinics are not able to maximize their potential due to several barriers reported in literature. These barriers range from human resources, to financial constraints.

A major difficulty that free clinics face is finding and retaining volunteer healthcare professionals. A recent study recorded a decline in the number of physicians volunteering from 2004 to 2005 by 10.3% (Darrow, 2007). Another study showed a more broad decline, indicating that from 1997 to 2005, the proportion of doctors seeing patients charitably has decreased by 8% overall (Issacs & Jellinek, 2007). Both studies had similar explanations; they reported that physicians face many issues that make the choice to volunteer a difficult one. With the number of uninsured individuals increasing, the volunteers are under most stress while volunteering, and when working in their own practice, doctors are receiving lower payments from insurance companies and are therefore facing their own economic pressures. Physicians also have to get malpractice insurance and proper licensing into account when deciding to volunteer. Retired physicians have to maintain medical education in order keep a license to be able to volunteer. All of

these issues are either costly or just a hassle and can act as a barrier, keeping physicians from volunteering their time (Darrow, 2007). Also relevant, in many states, the laws governing Physician Assistants largely prevent them from volunteering in a free clinic setting. This means that there is currently an entire array of health care providers who may be willing to volunteer, but are unable to do so (Davis, 2005).

As an additional issue may act to prevent some health care professionals from volunteering, one study suggested that physicians who did not find Medicaid compensation to the adequate were much less likely to be willing to provide free care at a free clinic. Many of the physicians stated that they felt that seeing Medicaid patients was charitable work because they were not receiving the compensation that they would from any other patient (Darnell, 2011). With health care reform, it seems quite possible that there will be many more individuals that have health insurance with lower compensation rates for physicians. If it is true that physicians are less likely to volunteer when they feel that they are not properly compensated, this change could impact the number of doctors supporting free clinics with their time and medical expertise.

Another issue stems from the increasing need for the services that are provided by free clinics, as the number of people in need of chronic care increases, the resources the clinic requires also increases. This put finical stress on the clinics, because they require more funding to be able to see and treat more chronic cases such as diabetes and heart disease. The need for medications to treat these patients

is also a struggle as prescription prices are often more than either clinics or patients can afford (Issacs & Jellinek, 2007).

Chapter 4: Conclusions

Future

With health care reform on horizon, the role played by free clinics may very well change. The populations served by these clinics have historically been the uninsured, and with current efforts to ensure that all citizens have medical insurance, it seems this population will be significantly impacted. However, the US congressional budget office estimates that 23 million people will remain uninsured after the healthcare reform (www.echoclinics.org, 2012). This is a significant reduction from the nearly 55 million that are currently uninsured, but it seems likely that there will still be a need for the free clinics to serve the remaining 23 million (US Congressional Budget office, 2010). One article suggests that the healthcare reform may cause short-term gaps in insurance coverage as the systems go through the transitions of reform which could lead to an even higher demand of free clinic services (Hall, 2011). Another study identifies free clinics as institutions that fill in the gaps to meet the needs that cannot be met through government programs. The author suggest that the government will be unable to fill these gaps completely with reform so they find it unlikely that free clinics will disappear completely (Darnell, 2011). This theory seems to be supported by another investigation on French free clinics. France has a health care system that theoretically guarantees access to healthcare to anyone living in the country. In spite of this system there have always been a large number of people who do not receive the benefits they should and there are still free clinics present acting as a safety net to provide these individuals with healthcare (Parizot, Chauvin & Paugam, 2005).

Also, a recent study reported that because a small number of insured people chose to attend a free clinic as well as a few free clinics that billed insurance companies, this was enough reason to believe that free clinics would be able to adapt to having more of their patients insured, instead of closing down because of their patients suddenly having coverage (Darnell, 2010).

Clinics are also beginning to play a larger role in community health education by providing people in their area with resources that were previously unavailable to them. A free clinic made health risk assessments available to its patients. These survey type assessments give patients an individualized report that explains the effects their lifestyles can have on their health and acts as an educational resource on how a change in lifestyle can lead to an improvement in their overall health (Scariati & Williams, 2007). It is still to be seen whether this and other health education resources provided by free clinics will have any affect on the overall level of health of a community, but education certainly seems like a good place to start.

Summary

Free clinics have clearly played a role in health care in the recent years. The studies that have been conducted indicate that clinics are a large part of the safety net trying to ensure that all people have access to health care regardless of their individual situations. Despite the major differences from clinic to clinic, all of the free clinics seem to be striving to provide the best quality care they can manage for their patients. Providing people with access to primary care is an important part of maintaining community health. Without these clinics the number of people either seeking primary care from emergency rooms or simply not seeking care at all would

increase significantly. In order to keep their doors open, clinics must deal with the issues of maintaining adequate funding and finding healthcare professionals willing to donate their time. Through the support of community organizations and individuals willing to finically contribute and physicians, nurses, pharmacists, and others willing to donate their time and expertise, free clinics are providing millions of patient visits, to people who otherwise would not be able to afford them, each year.

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